STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	09/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for investigation of Complaints IN00094960 and IN00095303. IN00094960-Substantiated. Federal/state deficiencies related to the allegations are cited at F 157 and F 282. IN00095303-Unsubstantiated due to lack of evidence. Survey dates: September 12, 13, 14, 2011 Facility number: 000153 Provider number: 155249 Aim number: 100266910 Survey team: Ann Armey, RN TC Carol Miller, RN Census bed type: SNF/NF: 142 Total: 142 Census payor type: Medicare: 8 Medicaid: 105 Other: 29 Total: 142 Sample: 9	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 9/15/11 Cathy Emswiller RN			
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the	F0157	The nursing center requests	10/14/2011

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	facility failed to notify the physician when a resident had a low blood sugar (Resident #D) and when a medication was not available (Resident #I). This deficiency affected 2 of 8 residents, whose medications and treatments were reviewed, in a sample of 9. Findings include: 1. The closed clinical record of Resident #D was reviewed on 9/12/11 at 3:00 p.m. and indicated the resident was admitted to the facility on 7/22/11 with diagnoses which included but were not limited to, insulin dependent diabetes mellitus, and cellulitis. Resident #D was discharged to home on 8/4/11. The August and September 2011 MAR (Medication Administration Record) indicated the resident was to have blood sugar checks before meals, at bed time and at 3:00 a.m. The MARs indicated if the blood sugar was less than 60 and the resident was responsive give 4 ounces of orange juice and notify the physician for further orders. On 8/2/11 at 2:11 a.m., progress notes indicated Resident #D was not feeling well and the resident's blood sugar was low at 43. The resident was given a can of		that this plan of correction be considered its credible allegation of compliance. Submission of the response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the nursing center, the administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the nursing center of the truth of any facts alleged or the corrections of conclusions set forth in this allegation by the survey agency. Accordingly, the nursing center has prepared and submitted this Plan of Correction prior to the resolution of appeal of this	

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	ensure and "Res (Resident) now WNL (Within Normal Limit)..." There was no documentation the physician was notified. The Diabetic Monitoring Flow Sheet indicated the blood sugar was retaken, and was 95. There was a check mark on the flow sheet indicating the physician was not notified. During interview, on 9/14/11 at 9:00 a.m., Unit Manager #3 indicated she was not able to find any faxes or documentation indicating the physician had been notified about Resident #D's low blood sugar. 2. Resident I's record was reviewed on 9/12/11 at 1:00 P.M. Resident I's diagnoses included but were not limited to, depression, anxiety, and chronic pain. On 9/7/11, a physician progress note indicated Resident #I was experiencing constipation, abdominal pain and nausea. On 9/7/11, a physician's order indicated Relistor (an antinausea medication) 12 mg was to be given subcutaneously every 48 hours. The Medication Administration Record		matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this time frame should in no way be construed as an admission of non-compliance by the nursing center. F157 I. 1. Resident #D no longer resides in the nursing center, therefore, no further corrective action could be taken for this resident. 2. The medication, Relistor, was on National Backorder. Thus, a physician order was obtained for Resident #I to discontinue the medication with an order for a replacement medication. II. The glucometer flow records of all residents have been reviewed with no additional concerns noted.	

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	dated September 2011 indicated on 9/10/11 and 9/12/11 at 8:00 A.M. the medication Relistor was circled as not given. On 9/13/11 at 10:00 A.M. the Assistant Director of Nursing (ADON) was interviewed in regard to the medication, Relistor, which was circled as not given on 9/10 and 9/12/11. The ADON indicated the medication Relistor was not in the facility and the Nurse on Saturday got busy and forgot to call the pharmacy and notify the physician. There was no documentation the physician was notified. The Diabetic Monitoring Flow Sheet indicated the blood sugar was retaken, and was 95. There was a check mark on the flow sheet indicating the physician was not notified. During interview, on 9/14/11 at 9:00 a.m., Unit Manager #3 indicated she was not able to find any faxes or documentation indicating the physician had been notified about Resident #D's low blood sugar. This Federal tag relates to Complaint IN00094960.		The Medication Administration Records (MARs) of all residents have been reviewed in an effort to identify any other medication concerns. No other concerns were identified. III. Licensed nurses have received in-service education relative to notification of changes, including but not limited to blood sugar readings outside of call parameters and medication concerns. A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, compliance with physician notification of abnormal blood sugar results and medication concerns. Any identified concerns will be promptly addressed with responsible individual(s). IV. DNS, or designee, will review findings weekly and report to PI committee monthly for 6	

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	3.1-5(a)(2) 3.1-5(a)(3)		months to determine need for continued monitoring thereafter. V. Completion Date: October 14, 2011	
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to follow physician orders in regard to administering a medication (Resident #I), providing a treatment (Resident #C), and notifying the physician when a blood sugar was low (Resident #D). The facility also failed to follow their policy for measuring an external catheter to assure proper placement and changing the injection caps of a resident with PICC (Peripherally Inserted Central Catheter) line (Resident #E) This deficiency affected 4 of 8 residents whose medication and treatments were reviewed in a sample of 9. Findings included 1. The closed clinical record of Resident #C was reviewed on 9/12/11 at 1:30 p.m. and indicated the resident was admitted to	F0282	F282 I. 1. & 2. Residents #C and #D no longer reside in the nursing center, therefore, no further corrective action could be taken for these residents. 3. Resident #E's PICC dressing and PICC caps were changed. 4. The medication, Relistor, was on National Backorder. Thus, a physician order was obtained for Resident #I to discontinue the medication with an order for a replacement medication. II. The Treatment Administration Records (TARs) and the Intravenous Flow Records of all residents have been reviewed in an effort to identify any other dressing or PICC/IV concerns with no concerns noted. The glucometer flow records of all residents have been reviewed with no additional concerns noted. The Medication Administration Records (MARs) of all residents have been reviewed in an effort to identify any other medication concerns	10/14/2011

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	the facility with an abdominal wound that cultured positive for MRSA (Methicillin Resistant Staphylococcus Aureus). Resident #C was discharged to home on 8/19/11. Admission orders, dated 8/9/11, indicated the abdominal wound was to be cleaned with normal saline, Iodoform packing, 1/2 inch, applied and covered with a dry sterile dressing three times daily. On 8/10/11 at 5:10 p.m., progress notes indicated Resident #C was upset because she had not received her wound treatments on the day shift. The resident indicated she was suppose to receive the treatment every eight hours and the treatment was done last night at 10:00 p.m. but had not been done since then. The August 2011 TAR (Treatment Administration Record) indicated the abdominal treatment was set up initially to be done on the day (7:00 a.m.-3:00 p.m.), evening (3:00 p.m.-11:00 p.m.) and night (11:00 p.m.-7:00 a.m.) shifts but was changed to be done at 6:00 a.m., 2:00 p.m. and 10:00 p.m. There was no documentation the 6:00 a.m. or 2:00 p.m. treatments were done on 8/10/11. During interview, on 9/13/11 at 10:00		with corrective action taken as necessary. III. Licensed Nurses have been in-serviced relative to following physician orders, including but not limited to medication and treatment administration, blood sugars outside of call parameters, and PICC line policies. Performance improvement tools have been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, compliance with following physician orders. Any identified concerns will be promptly addressed with responsible individual(s). IV. DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter. V. Completion Date: October 14, 2011	

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	a.m., the ADON (Assistant Director of Nursing) indicated the night and day shift treatments on 8/10/11, were "missed" but all the following treatments had been done. She indicated the incident was investigated and it was determined that there was a misunderstanding between nurses. The ADON indicated the day nurse thought the wound nurse was going to do the treatments and she did not do them. 2. The closed clinical record of Resident #D was reviewed on 9/12/11 at 3:00 p.m. and indicated the resident was admitted to the facility on 7/22/11 with diagnoses which included but were not limited to, insulin dependent diabetes mellitus, and cellulitis. Resident #D was discharged to home on 8/4/11. The August and September 2011 MAR (Medication Administration Record) indicated the resident was to have blood sugar checks before meals, at bed time and at 3:00 a.m. The MARs indicated if the blood sugar was less than 60 and the resident was responsive give 4 ounces of orange juice and notify the physician for further orders. On 8/2/11 at 2:11 a.m., progress notes			

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	indicated Resident #D was not feeling well and the resident's blood sugar was low at 43. The resident was given a can of ensure and "Res (Resident) now WNL (Within Normal Limit)..." There was no documentation the physician was notified. The Diabetic Monitoring Flow Sheet indicated the blood sugar was retaken, and was 95. There was a check mark on the flow sheet indicating the physician was not notified. During interview, on 9/14/11 at 9:00 a.m., Unit Manager #3 indicated she was not able to find any faxes or documentation indicating the physician had been notified about Resident #D's low blood sugar. 3. On 9/12/11 at 10:00 a.m. LPN #1 was observed administering Resident E's intravenous antibiotic, Vancomycin. PICC line. The access site was observed to be covered with a gauze dressing and the PICC line had a double lumen. The resident indicated her PICC line had been replaced on 9/11/11 and she felt she needed a dressing change to the PICC site. The clinical record of Resident # E was reviewed on 9/12/11 at 11:00 a.m. and			

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	indicated the resident was admitted to the facility with a diagnoses which included but were not limited to, an infected left knee and diabetes. The September 2011, Midline, CVAD (Central Venous Arterial Device) Documentation Form indicated the intravenous insertion site dressing should be changed every seven days and as needed. The form indicated the injection caps should be changed every seven days with dressing changes and as needed. The form further indicated the external PICC line catheter should be measured. There was no documentation the injection caps had been changed or the external catheter measured between 9/1-10/11. During interview, on 9/13/11 at 1:00 p.m., RN #2 indicated she had changed Resident #E's PICC dressing. RN #2 indicated she did not change the injection caps when she changed the dressing. during interview, on 9/14/11 at 9:00 a.m., Unit Manager #3 indicated the facility followed the pharmacy guidelines for PICC lines. Unit Manager #3 indicated the external PICC catheter should be measured and PICC access caps should be changed at least every week with the dressing changes. Unit Manager #3			

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	indicated this had not been done. 4. Resident I's record was reviewed on 9/12/11 at 1:00 P.M. Resident I's diagnoses included but were not limited to, depression, anxiety, and chronic pain. On 9/7/11, a physician progress note indicated Resident #I was experiencing constipation, abdominal pain and nausea. On 9/7/11, a physician's order indicated Relistor (an antinausea medication) 12 mg was to be given subcutaneously every 48 hours. The Medication Administration Record dated September 2011 indicated on 9/10/11 and 9/12/11 at 8:00 A.M. the medication Relistor was circled as not given. On 9/13/11 at 10:00 A.M. the Assistant Director of Nursing (ADON) was queried in regard to the medication, Relistor, which was circled as not given on 9/10 and 9/12/11. The ADON indicated the medication Relistor was not in the facility and the Nurse on Saturday got busy and forgot to call the pharmacy and notify the physician.			

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	This Federal tag relates to Complaint IN00094960. 3.1-35(g)(2)			